Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
ST DAVIDS HOSPITAL

Respondent Name
EMPLOYERS INSURANCE CO OF WAUSAU

MFDR Tracking Number
M4-15-1243-01

Carrier's Austin Representative
Box Number 01

MFDR Date Received
December 22, 2014

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Liberty Mutual underpaid the above referenced claim, in accordance with Texas State Worker's Compensation guidelines. According to the Texas Administrative Code 28.2.134.E. Rule 134.404, Liberty Mutual should pay:

(f) The reimbursement calculation used for establishing the MAR shall be the Medicare facility specific amount, including outlier payment amounts, determined by applying the most recently adopted and effective Medicare …

As we have already received payment in the amount of $9,207.41, please issue the additional **$2,881.11** that remains due to our facility at this time."

Amount in Dispute: $2,881.11

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "We have received the medical dispute filed by St. Davids Hospital for services rendered to [injured worker} for the 04/20/2013 date(s) of service. The bill and documentation attached to the medical dispute have been re-reviewed and our position remains unchanged. Our rationale is as follows:

Under Title 23 of the Texas Administrative Code Chapter 133 subchapter D Rule §133.307

A) A request for MFDR that does not involve issues identified in subparagraph (B) of this paragraph shall be filed no later than one year after the date(s) of service in dispute.

Please note that this dispute does not qualify for Medical Dispute as it does not meet the criteria as outlined in subparagraph B.

- The filed disputes does not address the issue of compensability
- The filed dispute is not in response of medical necessity"

Response Submitted by: Liberty Mutual Insurance

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
April 20, 2013 to April 22, 2013	Inpatient Hospital Services	$2,881.11	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - Z710 – The charge for this procedure exceeds the fee schedule allowance
   - P300 – Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement
   - P13 – Previously paid. Payment for this claim/service may have been provided in a previous payment
   - 193 – Original payment decision is being maintained. Upon review, it was determined that this claim has processed properly
   - X673 – Submit Intra-operative charge record that lists each component of implants used

Issue

1. Did the requestor waive the right to medical fee dispute resolution?

Findings

1. 28 Texas Administrative Code §133.307(c)(1) states: "Timeliness. A requestor shall timely file the request with the division's MFDR Section or waive the right to MFDR. The division shall deem a request to be filed on the date the MFDR Section receives the request. A decision by the MFDR Section that a request was not timely filed is not a dismissal and may be appealed pursuant to subsection (g) of this section. (A) A request for MFDR that does not involve issues identified in subparagraph (B) of this paragraph shall be filed no later than one year after the date(s) of service in dispute." The date of the services in dispute is April 20, 2013 to April 22, 2013. The request for medical dispute resolution was received in the Medical Fee Dispute Resolution (MFDR) section on December 22, 2014. This date is later than one year after the date(s) of service in dispute. Review of the submitted documentation finds that the disputed services do not involve issues identified in §133.307(c)(1)(B). The Division concludes that the requestor has failed to timely file this dispute with the Division's MFDR Section; consequently, the requestor has waived the right to medical fee dispute resolution.

Conclusion

The Division finds that the requestor has waived the right to medical fee dispute resolution for the services in dispute, as addressed in 28 Texas Administrative Code §133.307(c)(1) and (c)(1)(A). For that reason, the merits of the issues raised by the parties to this dispute have not been addressed.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the services in dispute.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	3/17/15 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.